THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1346	PERIOD FROM 1/ 1/2009 TO 12/31/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 5/24/2010 TIME 11:08

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
FAYETTE COUNTY HOSPITAL 14-1346
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 5/24/2010 TIME 11:08
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jpzHKNW38c32MdSpQCM4NF.FmMqu20
vxNBM0MT2rgmUIl9eqkfSt0rzwbpBX
WqgG0yI.NZ0:Isew

PI ENCRYPTION INFORMATION
DATE: 5/24/2010 TIME 11:08
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bnQPVp:9t.2l0ka.OfbO24WF.Z7O40
H6:gF022omajgDLJdBKbRLknAFwgxO
wSOy40Wxyv08f3o5

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	HOSPITAL	0	61,110	-152,747		0
3	SWING BED - SNF	0	-80,801	0		0
5	HOSPITAL-BASED SNF	0	19,444	0		0
100	TOTAL	0	-247	-152,747		0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1346	PERIOD FROM 1/ 1/2009 TO 12/31/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 5/20/2010 TIME 15:30

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

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FAYETTE COUNTY HOSPITAL 14-1346
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX
		1	A 2	B 3	4
1	HOSPITAL	0	61,110	-152,747	0
3	SWING BED - SNF	0	-80,801	0	0
5	HOSPITAL-BASED SNF	0	19,444	0	0
100	TOTAL	0	-247	-152,747	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96 (01/2010)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: SEVENTH & TAYLOR P.O. BOX:
11 CITY: VANDALIA STATE: IL ZIP CODE: 62471- COUNTY: FAYETTE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	FAYETTE COUNTY HOSPITAL	14-1346		4/ 1/2005	N	O	O
04.00	SWING BED - SNF	FAYETTE COUNTY SNF	14-Z346		4/ 1/2005	N	O	N
06.00	HOSPITAL-BASED SNF	FAYETTE COUNTY SNF	14-5499		7/ 1/1983	N	P	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2009 TO: 12/31/2009

		1	2
18	TYPE OF CONTROL	2	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1
20	SUBPROVIDER	

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.				
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.	N			
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).				
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	N	Y	14999
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2			
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2			
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	N			
21.07	DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)				
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.				
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N			
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N			
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.			/ /	/ /
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)				/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).				/ /

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?				N	
01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?				N	
02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.					
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.				N	
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.				N	
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)					
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)					
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				0	
26.01	ENTER THE APPLICABLE SCH DATES:	BEGINNING: / /	ENDING: / /			
26.02	ENTER THE APPLICABLE SCH DATES:	BEGINNING: / /	ENDING: / /			
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.				Y	6/25/2001
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02				N	

		1	2	3	4
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	100	0.8386	0.8312	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	2	14	99914

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

		%	Y/N
28.03	STAFFING	1.00%	Y
28.04	RECRUITMENT	0.00%	
05	RETENTION	0.00%	
06	TRAINING	0.00%	

	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N	
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y	
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N	
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N	
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N	
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N	
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	

MISCELLANEOUS COST REPORT INFORMATION

32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N	
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N	N
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N	
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	

		V	XVIII	XIX
	SPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3
	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N

	TITLE XIX INPATIENT SERVICES		
38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y	
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N	
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N	
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N	
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	Y	
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	Y		
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #	
40.02	STREET: P.O. BOX:			
40.03	CITY: STATE: ZIP CODE: -			
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N		
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000	
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).			

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
49.00	HOSPITAL N	N	N	N	N
49.00	SNF N	N			

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 0		
	PAID LOSSES: 0		
	AND/OR SELF INSURANCE: 0		
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

		DATE	Y OR N	LIMIT	Y OR N	FEES
		0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). 0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

TLEMENT DATA

.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS: TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	21	7,665	57,624.00		2,081		307
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					2,100		
4	ADULTS & PED-SB NF							88
5	TOTAL ADULTS AND PEDS	21	7,665	57,624.00		4,181		395
6	INTENSIVE CARE UNIT	4	1,460	9,840.00		304		
12	TOTAL	25	9,125	67,464.00		4,485		395
13	RPCH VISITS							
15	SKILLED NURSING FACILITY	16	5,840			1,146		
16	NURSING FACILITY	69	25,185					
25	TOTAL	110						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / O/P VISITS / TRIPS: TITLE XIX ADMITTED 5.01	OBSERVATION BEDS NOT ADMITTED 5.02	TOTAL ALL PATS 6	TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			2,717				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			2,100				
4	ADULTS & PED-SB NF			88				
5	TOTAL ADULTS AND PEDS			4,905				
6	INTENSIVE CARE UNIT			410				
12	TOTAL			5,315				
13	RPCH VISITS							
15	SKILLED NURSING FACILITY			1,603				
16	NURSING FACILITY			22,775				
25	TOTAL							
26	OBSERVATION BED DAYS			556		556		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					764	123	1,104
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
12	TOTAL		173.78			764	123	1,104
13	RPCH VISITS							
15	SKILLED NURSING FACILITY		4.62					
16	NURSING FACILITY		43.31					
25	TOTAL		221.71					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET S-7

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

	GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	SERVICES PRIOR TO 10/1 DAYS	SERVICES ON/AFTER 10/1 RATE	SERVICES ON/AFTER 10/1 DAYS	SRVCS 4/1/01 TO 9/30/01 RATE	SRVCS 4/1/01 TO 9/30/01 DAYS
	1	2	3	3.01	4	4.01	4.02	4.03
1		RUC						
2		RUB						
3		RUA						
3	.01	RUX						
3	.02	RUL						
4		RVC		10				
5		RVB		39				
6		RVA		2				
6	.01	RVX		12				
6	.02	RVL						
7		RHC		67				
8		RHB		34				
9		RHA						
9	.01	RHX						
9	.02	RHL						
10		RMC						
11		RMB		18				
12		RMA		7				
12	.01	RMX		161				
12	.02	RML		302				
13		RLB						
14		RLA						
14	.01	RLX						
15		SE3		421				
16		SE2		34				
17		SE1						
18		SSC						
19		SSB						
20		SSA		23				
21		CC2						
22		CC1						
23		CB2						
24		CB1		8				
25		CA2						
26		CA1		7				
27		IB2						
28		IB1						
29		IA2						
30		IA1						
31		BB2						
32		BB1						
33		BA2						
34		BA1						
35		PE2						
36		PE1						
37		PD2						
38		PD1						
39		PC2						
40		PC1						
41		PB2						
42		PB1		1				
43		PA2						
44		PA1						
45		AAA						
46		TOTAL		1,146				

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:

Transition Period	100% Federal
Wage Index Factor (before 10/01)	0.8386
Wage Index Factor (after 10/01)	0.8312
SNF Facility Specific Rate	0.00
Urban/Rural Designation	RURAL
SNF MSA Code	14
SNF CBSA Code	99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

PROVIDER NO:	PERIOD:	PREPARED	WORKSHEET
14-1346	FROM 1/ 1/2009	5/20/2010	S-7
	TO 12/31/2009		

	GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGs DAYS	SWING BED SNF DAYS	TOTAL
		1	2	4.05	4.06	5
1		RUC				
2		RUB				
3		RUA				
3	.01	RUX				
3	.02	RUL				
4		RVC				
5		RVB				
6		RVA				
6	.01	RVX				
6	.02	RVL				
7		RHC				
8		RHB				
9		RHA				
9	.01	RHX				
9	.02	RHL				
10		RMC				
11		RMB				
12		RMA				
12	.01	RMX				
12	.02	RML				
13		RLB				
14		RLA				
14	.01	RLX				
15		SE3				
16		SE2				
17		SE1				
18		SSC				
19		SSB				
20		SSA				
21		CC2				
22		CC1				
23		CB2				
24		CB1				
25		CA2				
26		CA1				
27		IB2				
28		IB1				
29		IA2				
30		IA1				
31		BB2				
32		BB1				
33		BA2				
34		BA1				
35		PE2				
36		PE1				
37		PD2				
38		PD1				
39		PC2				
40		PC1				
41		PB2				
42		PB1				
43		PA2				
44		PA1				
45		AAA				
46		TOTAL				

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

Worksheet S-2 reference data:

Transition Period	100% Federal
Wage Index Factor (before 10/01)	0.8386
Wage Index Factor (after 10/01)	0.8312
SNF Facility Specific Rate	0.00
Urban/Rural Designation	RURAL
SNF MSA Code	14
SNF CBSA Code	99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET S-7 I NOT A CMS WORKSHEET SERVICES THROUGH 12/31/2005

	GROUP(1)	M3PI REVENUE CODE	SERVICES BASE RATE	PRIOR TO RATE	OCTOBER 1ST DAYS	SERVICES BASE RATE	ON OR AFTER RATE	OCTOBER 1ST DAYS
	1		3a	3	3.01	4a	4	4.01
1	RUC		497.80			495.77		
2	RUB		460.49			459.15		
3	RUA		441.19			440.83		
3 .01	RUX		577.55			570.35		
3 .02	RUL		513.24			510.17		
4	RVC		393.12	393.12	10	388.01		
5	RVB		375.12	375.12	39	371.01		
6	RVA		340.39	340.39	2	339.61		
6 .01	RVX		433.00	433.00	12	427.27		
6 .02	RVL		405.99			401.10		
7	RHC		336.86	336.86	67	330.81		
8	RHB		322.72	322.72	34	317.73		
9	RHA		300.84			298.10		
9 .01	RHX		362.60			356.97		
9 .02	RHL		356.16			349.12		
10	RMC		307.99			302.74		
11	RMB		300.27	300.27	18	294.89		
12	RMA		293.84	293.84	7	289.66		
12 .01	RMX		408.32	408.32	161	398.25		
12 .02	RML		376.16	376.16	302	368.16		
13	RLB		266.93			261.00		
14	RLA		229.62			225.67		
14 .01	RLX		288.79			281.93		
15	SE3		323.53	323.53	421	310.71		
16	SE2		275.94	275.94	34	266.23		
17	SE1		246.34			238.75		
18	SSC		242.48			234.83		
19	SSB		229.62			223.06		
20	SSA		225.77	225.77	23	219.13		
21	CC2		241.20			233.52		
22	CC1		220.62			215.21		
23	CB2		210.32			204.74		
24	CB1		201.32	201.32	8	195.58		
25	CA2		200.03			194.28		
26	CA1		187.17	187.17	7	183.80		
27	IB2		179.45			175.95		
28	IB1		176.88			173.34		
29	IA2		162.73			160.26		
30	IA1		156.29			155.02		
31	BB2		178.17			174.65		
32	BB1		173.02			170.72		
33	BA2		161.44			158.95		
34	BA1		151.15			148.49		
35	PE2		193.60			189.04		
36	PE1		189.75			186.43		
37	PD2		184.60			179.88		
38	PD1		182.03			177.27		
39	PC2		175.59			172.03		
40	PC1		173.02			170.72		
41	PB2		155.01			153.72		
42	PB1		153.72	153.72	1	151.10		
43	PA2		152.43			149.79		
44	PA1		148.58			145.87		
45	AAA		148.58			145.87		
46	TOTAL				1,146			

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:
Transition Period : 100% Federal
Wage Index Factor (before 10/01): 0.8386
Wage Index Factor (after 10/01) : 0.8312
SNF Facility Specific Rate : 0.00
Urban/Rural Designation : RURAL
SNF MSA Code : 14
SNF CBSA Code : 99914

Non-CMS S-7 options selected:
[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET S-7 I NOT A CMS WORKSHEET SERVICES THROUGH 12/31/2005

	GROUP(1)	M3PI REVENUE CODE	AIDS DIAGNOSIS CODE 042 SERV PRIOR TO OCT. 1ST RATE	AIDS DIAGNOSIS CODE 042 SERV PRIOR TO OCT. 1ST DAYS	AIDS DIAGNOSIS CODE 042 SERV ON/AFTEER OCT. 1ST RATE	AIDS DIAGNOSIS CODE 042 SERV ON/AFTEER OCT. 1ST DAYS	SWING BED SNF DAYS	TOTAL
	1	2	4.02	4.03	4.04	4.05	4.06	5
1	RUC		1,134.98		1,130.36			
2	RUB		1,049.92		1,046.86			
3	RUA		1,005.91		1,005.09			
3 .01	RUX		1,316.81		1,300.40			
3 .02	RUL		1,170.19		1,163.19			
4	RVC		896.31		884.66			3,931
5	RVB		855.27		845.90			14,630
6	RVA		776.09		774.31			681
6 .01	RVX		987.24		974.18			5,196
6 .02	RVL		925.66		914.51			
7	RHC		768.04		754.25			22,570
8	RHB		735.80		724.42			10,972
9	RHA		685.92		679.67			
9 .01	RHX		826.73		813.89			
9 .02	RHL		812.04		795.99			
10	RMC		702.22		690.25			
11	RMB		684.62		672.35			5,405
12	RMA		669.96		660.42			2,057
12 .01	RMX		930.97		908.01			65,740
12 .02	RML		857.64		839.40			113,600
13	RLB		608.60		595.08			
14	RLA		523.53		514.53			
14 .01	RLX		658.44		642.80			
15	SE3		737.65		708.42			136,206
16	SE2		629.14		607.00			9,382
17	SE1		561.66		544.35			
18	SSC		552.85		535.41			
19	SSB		523.53		508.58			
20	SSA		514.76		499.62			5,193
21	CC2		549.94		532.43			
22	CC1		503.01		490.68			
23	CB2		479.53		466.81			
24	CB1		459.01		445.92			1,611
25	CA2		456.07		442.96			
26	CA1		426.75		419.06			1,310
27	IB2		409.15		401.17			
28	IB1		403.29		395.22			
29	IA2		371.02		365.39			
30	IA1		356.34		353.45			
31	BB2		406.23		398.20			
32	BB1		394.49		389.24			
33	BA2		368.08		362.41			
34	BA1		344.62		338.56			
35	PE2		441.41		431.01			
36	PE1		432.63		425.06			
37	PD2		420.89		410.13			
38	PD1		415.03		404.18			
39	PC2		400.35		392.23			
40	PC1		394.49		389.24			
41	PB2		353.42		350.48			
42	PB1		350.48		344.51			154
43	PA2		347.54		341.52			
44	PA1		338.76		332.58			
45	AAA		338.76		332.58			
46	TOTAL							398,638

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

Worksheet S-2 reference data:
Transition Period : 100% Federal
Wage Index Factor (before 10/01): 0.8386
Wage Index Factor (after 10/01) : 0.8312
SNF Facility Specific Rate : 0.00
Urban/Rural Designation : RURAL
SNF MSA Code : 14
SNF CBSA Code : 99914

Non-CMS S-7 options selected:
[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET S-10
	TO 12/31/2009	

	DESCRIPTION	
	UNCOMPENSATED CARE INFORMATION	
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04	OTHER METHODS OF WRITE-OFFS (SPEC.)	
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
	UNCOMPENSATED CARE REVENUES	
17	REVENUE FROM UNCOMPENSATED CARE	384,179
17.01	GROSS MEDICAID REVENUES	2,605,332
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	2,989,511
	UNCOMPENSATED CARE COST	
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.369892
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	2,605,332

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET S-10

	DESCRIPTION	
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	963,691
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	963,691

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		756,628	756,628	-196,308	560,320
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				150,114	150,114
5	0500	EMPLOYEE BENEFITS	88,172	1,783,543	1,871,715	7,374	1,879,089
6	0600	ADMINISTRATIVE & GENERAL	481,015	2,943,622	3,424,637	100,076	3,524,713
8	0800	OPERATION OF PLANT	217,932	78,236	296,168	12,717	308,885
8.01	0801	OPERATION OF PLANT HOSP ONLY		625,030	625,030		625,030
8.02	0802	OPERATION OF PLANT ANNEX ONLY		11,054	11,054		11,054
9	0900	LAUNDRY & LINEN SERVICE	79,914	14,792	94,706		94,706
10	1000	HOUSEKEEPING	362,007	114,854	476,861		476,861
11	1100	DIETARY	290,210	401,182	691,392	-262,897	428,495
12	1200	CAFETERIA				262,897	262,897
14	1400	NURSING ADMINISTRATION	358,292	30,144	388,436		388,436
15	1500	CENTRAL SERVICES & SUPPLY	60,268	32,078	92,346		92,346
16	1600	PHARMACY	64,420	301,259	365,679		365,679
17	1700	MEDICAL RECORDS & LIBRARY	286,751	101,891	388,642		388,642
20	2000	NONPHYSICIAN ANESTHETISTS				378,275	378,275
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,106,335	188,551	1,294,886	-55,188	1,239,698
26	2600	INTENSIVE CARE UNIT	272,059	30,976	303,035	-8,526	294,509
34	3400	SKILLED NURSING FACILITY	175,602	28,727	204,329	4,971	209,300
35	3500	NURSING FACILITY	1,502,039	298,485	1,800,524	-84,515	1,716,009
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	302,488	338,104	640,592	-273,019	367,573
40	4000	ANESTHESIOLOGY		394,903	394,903	-383,817	11,086
41	4100	RADIOLOGY-DIAGNOSTIC	423,828	829,731	1,253,559	-15,599	1,237,960
42	4200	RADIOLOGY-THERAPEUTIC		212,207	212,207	-2,055	210,152
44	4400	LABORATORY	478,931	682,637	1,161,568	-27,679	1,133,889
49	4900	RESPIRATORY THERAPY	340,802	177,679	518,481	-31,861	486,620
50	5000	PHYSICAL THERAPY	392,773	39,906	432,679	-3,073	429,606
52	5200	SPEECH PATHOLOGY	26,958	1,538	28,496	-42	28,454
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		149,879	149,879	532,741	682,620
56	5600	DRUGS CHARGED TO PATIENTS		714,857	714,857	35,290	750,147
59	3160	OP PSYCH		586,097	586,097	-200	585,897
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	346,541	1,141,044	1,487,585	231,391	1,718,976
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
		OTHER REIMBURS COST CNTRS					
75	6500	AMBULANCE SERVICES	343,253	99,764	443,017	-275,332	167,685
		SPEC PURPOSE COST CENTERS					
95		SUBTOTALS	8,000,590	13,109,398	21,109,988	95,735	21,205,723
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	1,034,677	120,754	1,155,431	-29,136	1,126,295
98.01	9801	FAYETTE COUNTY MEDICAL CENTER		66,598	66,598	-66,599	-1
98.02	9802	PUBLIC RELATIONS	23,487	28,449	51,936		51,936
98.03	9803	PERSONAL LAUNDRY					
98.04	9804	VIS MEALS & MEALS ON WHEELS					
101		TOTAL	9,058,754	13,325,199	22,383,953	-0-	22,383,953

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-12,046	548,274
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		150,114
5	0500	EMPLOYEE BENEFITS	-2,606	1,876,483
6	0600	ADMINISTRATIVE & GENERAL	-59,366	3,465,347
8	0800	OPERATION OF PLANT	-2,853	306,032
8.01	0801	OPERATION OF PLANT HOSP ONLY		625,030
8.02	0802	OPERATION OF PLANT ANNEX ONLY		11,054
9	0900	LAUNDRY & LINEN SERVICE		94,706
10	1000	HOUSEKEEPING		476,861
11	1100	DIETARY	-56,824	371,671
12	1200	CAFETERIA		262,897
14	1400	NURSING ADMINISTRATION		388,436
15	1500	CENTRAL SERVICES & SUPPLY		92,346
16	1600	PHARMACY		365,679
17	1700	MEDICAL RECORDS & LIBRARY	-10,524	378,118
20	2000	NONPHYSICIAN ANESTHETISTS	-378,275	
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,239,698
26	2600	INTENSIVE CARE UNIT		294,509
34	3400	SKILLED NURSING FACILITY		209,300
35	3500	NURSING FACILITY	-492,000	1,224,009
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		367,573
40	4000	ANESTHESIOLOGY		11,086
41	4100	RADIOLOGY-DIAGNOSTIC	-56	1,237,904
42	4200	RADIOLOGY-THERAPEUTIC		210,152
44	4400	LABORATORY	-22,917	1,110,972
49	4900	RESPIRATORY THERAPY		486,620
50	5000	PHYSICAL THERAPY		429,606
52	5200	SPEECH PATHOLOGY		28,454
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		682,620
56	5600	DRUGS CHARGED TO PATIENTS		750,147
59	3160	OP PSYCH		585,897
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-745,884	973,092
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
		OTHER REIMBURS COST CNTRS		
75	6500	AMBULANCE SERVICES		167,685
		SPEC PURPOSE COST CENTERS		
95		SUBTOTALS	-1,783,351	19,422,372
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		1,126,295
98.01	9801	FAYETTE COUNTY MEDICAL CENTER		-1
98.02	9802	PUBLIC RELATIONS		51,936
98.03	9803	PERSONAL LAUNDRY		
98.04	9804	VIS MEALS & MEALS ON WHEELS		
101		TOTAL	-1,783,351	20,600,602

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(7/2009)

COST CENTERS USED IN COST REPORT

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I NOT A CMS WORKSHEET

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
8.01	OPERATION OF PLANT HOSP ONLY	0801	OPERATION OF PLANT
8.02	OPERATION OF PLANT ANNEX ONLY	0802	OPERATION OF PLANT
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
52	SPEECH PATHOLOGY	5200	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	OP PSYCH	3160	CARDIOPULMONARY
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
3	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	FAYETTE COUNTY MEDICAL CENTER	9801	PHYSICIANS' PRIVATE OFFICES
98.02	PUBLIC RELATIONS	9802	PHYSICIANS' PRIVATE OFFICES
98.03	PERSONAL LAUNDRY	9803	PHYSICIANS' PRIVATE OFFICES
98.04	VIS MEALS & MEALS ON WHEELS	9804	PHYSICIANS' PRIVATE OFFICES
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
		1	2	3	4	5
1	CAFETERIA	A	CAFETERIA	12	110,350	152,547
2	CRNA	B	NONPHYSICIAN ANESTHETISTS	20		378,275
3	NURSE ADMIN	C	SKILLED NURSING FACILITY	34	14,612	72
4	DEPRECIATION	D	NEW CAP REL COSTS-MVBLE EQUIP	4		150,114
5	ER IN AMBULANCE	E	EMERGENCY	61	267,871	
6	OPERATING INTEREST	F	ADMINISTRATIVE & GENERAL	6		67,946
7	OPERATING INSURANCE	G	ADMINISTRATIVE & GENERAL	6		29,773
8	EMP OCC HEALTH PROCEDURES	H	EMPLOYEE BENEFITS	5	5,365	2,009
9	WELLNESS DEPR/UTILITIES	I	NEW CAP REL COSTS-BLDG & FIXT	3		51,525
10			ADMINISTRATIVE & GENERAL	6		2,357
11			OPERATION OF PLANT	8		12,717
12	MED SUPPLY	J	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		532,741
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28	PHARMACY RECLASS	K	DRUGS CHARGED TO PATIENTS	56		35,290
29						
30						
31						
32						
33						
34						
35						
	PHARMACY RECLASS	K				
3						
4						
5						
36	TOTAL RECLASSIFICATIONS				398,198	1,415,366

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 6	LINE NO 7	DECREASE SALARY 8	DECREASE OTHER 9	A-7 REF 10
1	CAFETERIA	A	DIETARY	11	110,350	152,547	
2	CRNA	B	ANESTHESIOLOGY	40		378,275	
3	NURSE ADMIN	C	NURSING FACILITY	35	14,612	72	
4	DEPRECIATION	D	NEW CAP REL COSTS-BLDG & FIXT	3		150,114	9
5	ER IN AMBULANCE	E	AMBULANCE SERVICES	65	267,871		
6	OPERATING INTEREST	F	NEW CAP REL COSTS-BLDG & FIXT	3		67,946	10
7	OPERATING INSURANCE	G	NEW CAP REL COSTS-BLDG & FIXT	3		29,773	11
8	EMP OCC HEALTH PROCEDURES	H	PHYSICIANS' PRIVATE OFFICES	98	5,365	2,009	
9	WELLNESS DEPR/UTILITIES	I	FAYETTE COUNTY MEDICAL CENTER	98.01		66,599	9
10							
11							
12	MED SUPPLY	J	ADULTS & PEDIATRICS	25		50,584	
13			INTENSIVE CARE UNIT	26		7,561	
14			SKILLED NURSING FACILITY	34		8,550	
15			NURSING FACILITY	35		55,330	
16			OPERATING ROOM	37		270,467	
17			ANESTHESIOLOGY	40		5,542	
18			RADIOLOGY-DIAGNOSTIC	41		14,128	
19			RADIOLOGY-THERAPEUTIC	42		11	
20			LABORATORY	44		27,518	
21			RESPIRATORY THERAPY	49		31,814	
22			PHYSICAL THERAPY	50		3,055	
23			SPEECH PATHOLOGY	52		42	
24			OP PSYCH	59		200	
25			EMERGENCY	61		34,235	
26			AMBULANCE SERVICES	65		4,623	
27			PHYSICIANS' PRIVATE OFFICES	98		19,081	
28	PHARMACY RECLASS	K	ADULTS & PEDIATRICS	25		4,604	
29			INTENSIVE CARE UNIT	26		965	
30			SKILLED NURSING FACILITY	34		1,163	
31			NURSING FACILITY	35		14,501	
32			OPERATING ROOM	37		2,552	
33			RADIOLOGY-DIAGNOSTIC	41		1,471	
34			RADIOLOGY-THERAPEUTIC	42		2,044	
35			LABORATORY	44		161	
	PHARMACY RECLASS	K	RESPIRATORY THERAPY	49		47	
2			PHYSICAL THERAPY	50		18	
3			EMERGENCY	61		2,245	
4			AMBULANCE SERVICES	65		2,838	
5			PHYSICIANS' PRIVATE OFFICES	98		2,681	
36	TOTAL RECLASSIFICATIONS				398,198	1,415,366	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A
EXPLANATION : CAFETERIA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	262,897	DIETARY	11	262,897
TOTAL RECLASSIFICATIONS FOR CODE A			262,897			262,897

RECLASS CODE: B
EXPLANATION : CRNA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NONPHYSICIAN ANESTHETISTS	20	378,275	ANESTHESIOLOGY	40	378,275
TOTAL RECLASSIFICATIONS FOR CODE B			378,275			378,275

RECLASS CODE: C
EXPLANATION : NURSE ADMIN

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	SKILLED NURSING FACILITY	34	14,684	NURSING FACILITY	35	14,684
TOTAL RECLASSIFICATIONS FOR CODE C			14,684			14,684

RECLASS CODE: D
EXPLANATION : DEPRECIATION

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	150,114	NEW CAP REL COSTS-BLDG & FIXT	3	150,114
TOTAL RECLASSIFICATIONS FOR CODE D			150,114			150,114

RECLASS CODE: E
EXPLANATION : ER IN AMBULANCE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	EMERGENCY	61	267,871	AMBULANCE SERVICES	65	267,871
TOTAL RECLASSIFICATIONS FOR CODE E			267,871			267,871

RECLASS CODE: F
EXPLANATION : OPERATING INTEREST

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	67,946	NEW CAP REL COSTS-BLDG & FIXT	3	67,946
TOTAL RECLASSIFICATIONS FOR CODE F			67,946			67,946

RECLASS CODE: G
EXPLANATION : OPERATING INSURANCE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	29,773	NEW CAP REL COSTS-BLDG & FIXT	3	29,773
TOTAL RECLASSIFICATIONS FOR CODE G			29,773			29,773

RECLASS CODE: H
EXPLANATION : EMP OCC HEALTH PROCEDURES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	EMPLOYEE BENEFITS	5	7,374	PHYSICIANS' PRIVATE OFFICES	98	7,374
TOTAL RECLASSIFICATIONS FOR CODE H			7,374			7,374

RECLASS CODE: I
EXPLANATION : WELLNESS DEPR/UTILITIES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	51,525	FAYETTE COUNTY MEDICAL CENTER	98.01	66,599
2.00	ADMINISTRATIVE & GENERAL	6	2,357			0
3.00	OPERATION OF PLANT	8	12,717			0
TOTAL RECLASSIFICATIONS FOR CODE I			66,599			66,599

RECLASS CODE: J
EXPLANATION : MED SUPPLY

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	532,741	ADULTS & PEDIATRICS	25	50,584
2.00			0	INTENSIVE CARE UNIT	26	7,561
3.00			0	SKILLED NURSING FACILITY	34	8,550
4.00			0	NURSING FACILITY	35	55,330
5.00			0	OPERATING ROOM	37	270,467
6.00			0	ANESTHESIOLOGY	40	5,542
7.00			0	RADIOLOGY-DIAGNOSTIC	41	14,128
8.00			0	RADIOLOGY-THERAPEUTIC	42	11
9.00			0	LABORATORY	44	27,518
10.00			0	RESPIRATORY THERAPY	49	31,814
11.00			0	PHYSICAL THERAPY	50	3,055
12.00			0	SPEECH PATHOLOGY	52	42
13.00			0	OP PSYCH	59	200
14.00			0	EMERGENCY	61	34,235
15.00			0	AMBULANCE SERVICES	65	4,623
16.00			0	PHYSICIANS' PRIVATE OFFICES	98	19,081
TOTAL RECLASSIFICATIONS FOR CODE J			532,741			532,741

RECLASS CODE: K
EXPLANATION : PHARMACY RECLASS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	35,290	ADULTS & PEDIATRICS	25	4,604
2.00			0	INTENSIVE CARE UNIT	26	965
3.00			0	SKILLED NURSING FACILITY	34	1,163
4.00			0	NURSING FACILITY	35	14,501
5.00			0	OPERATING ROOM	37	2,552
7.00			0	RADIOLOGY-DIAGNOSTIC	41	1,471
8.00			0	RADIOLOGY-THERAPEUTIC	42	2,044
9.00			0	LABORATORY	44	161
10.00			0	RESPIRATORY THERAPY	49	47
11.00			0	PHYSICAL THERAPY	50	18
12.00			0	EMERGENCY	61	2,245
13.00			0	AMBULANCE SERVICES	65	2,838
14.00			0	PHYSICIANS' PRIVATE OFFICES	98	2,681
TOTAL RECLASSIFICATIONS FOR CODE K			35,290			35,290

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

PROVIDER NO: 14-1346

PERIOD: FROM 1/ 1/2009 TO 12/31/2009

PREPARED 5/20/2010

WORKSHEET A-7

PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	1,109,949	2,539,627		2,539,627		3,649,576	
6	MOVABLE EQUIPMENT							
7	SUBTOTAL	1,109,949	2,539,627		2,539,627		3,649,576	
8	RECONCILING ITEMS							
9	TOTAL	1,109,949	2,539,627		2,539,627		3,649,576	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV	997,892		997,892	1.000000				
5	TOTAL	997,892		997,892	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	645,993	-67,946	-29,773				548,274
4	NEW CAP REL COSTS-MV	150,114						150,114
5	TOTAL	796,107	-67,946	-29,773				698,388

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	756,628						756,628
4	NEW CAP REL COSTS-MV							
5	TOTAL	756,628						756,628

* All lines numbers except line 5 are to be consistent with Workhseet A line numbers for capital cost centers.
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES	B	-12,046	NEW CAP REL COSTS-BLDG &	3	9
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-4,297	ADMINISTRATIVE & GENERAL	6	
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-768,801			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-56,824	DIETARY	11	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-10,524	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES	B	-2,853	OPERATION OF PLANT	8	
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3		**COST CENTER DELETED**	71	
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST	A	-378,275	NONPHYSICIAN ANESTHETISTS	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37	RECRUITMENT	A	-35,000	ADMINISTRATIVE & GENERAL	6	
37.01	MISCELLANEOUS REVENUE	B	-8,723	ADMINISTRATIVE & GENERAL	6	
37.02	NURSING HOME DISTRICT PAYMENT	B	-492,000	NURSING FACILITY	35	
37.03	AHA/IHA	A	-11,346	ADMINISTRATIVE & GENERAL	6	
37.04	EMPLOYEE BENEFIT OTHER REVENUE	A	-2,606	EMPLOYEE BENEFITS	5	
37.05						
37.06						
37.07	RADIOLOGY OTHER REVENUE	A	-56	RADIOLOGY-DIAGNOSTIC	41	
37.08						
37.09						
37.10						
37.11						
37.12						
38	OTHER ADJUSTMENTS (SPECIFY)					
39	OTHER ADJUSTMENTS (SPECIFY)					
40	OTHER ADJUSTMENTS (SPECIFY)					
41	OTHER ADJUSTMENTS (SPECIFY)					
42	OTHER ADJUSTMENTS (SPECIFY)					
43	OTHER ADJUSTMENTS (SPECIFY)					
44	OTHER ADJUSTMENTS (SPECIFY)					
45	OTHER ADJUSTMENTS (SPECIFY)					
46	OTHER ADJUSTMENTS (SPECIFY)					
47	OTHER ADJUSTMENTS (SPECIFY)					
48	OTHER ADJUSTMENTS (SPECIFY)					
49	OTHER ADJUSTMENTS (SPECIFY)					
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,783,351			

(1) Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1 6	ADMINISTRATIVE & GENERAL	ALLIANT MANAGEMENT	57,086	57,086		
2 41	RADIOLOGY-DIAGNOSTIC	BLUE GRASS LEASING	28,046	28,046		
3 6	ADMINISTRATIVE & GENERAL	ALLIANT PURCHASING	7,800	7,800		
4						
4.01						
4.02						
4.03						
4.04						
4.05						
4.06						
4.07						
4.08						
4.09						
4.10						
4.11						
4.12						
5	TOTALS		92,932	92,932		

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	B	ALLIANT MANAGEMENT	0.00		0.00	
2	B	BLUEGRASS LEASING	0.00		0.00	
3	B	ALLIANT PURCHASING	0.00		0.00	
4	B		0.00		0.00	
5	B		0.00		0.00	
5.01	B		0.00		0.00	
5.02	B		0.00		0.00	
5.03	B		0.00		0.00	
5.04	B		0.00		0.00	
5.05	B		0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERELATIONSHIP TO RELATED ORGANIZATIONS:

A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY	22,917	22,917					
2	61	ER	1,050,202	745,884	304,318				
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
101		TOTAL	1,073,119	768,801	304,318				

	WKSHT A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	44	LABORATORY							22,917
2	61	ER							745,884
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
101		TOTAL							768,801

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(7/2009)

COST ALLOCATION STATISTICS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I NOT A CMS WORKSHEET I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
1	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	6	SQ FT	ENTERED
8.01	OPERATION OF PLANT HOSP ONLY	7	SQ FT	ENTERED
8.02	OPERATION OF PLANT ANNEX ONLY	8	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	9	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	1	SQUARE FEET	ENTERED
11	DIETARY	11	MEALS SERVED	ENTERED
12	CAFETERIA	12	NUMBER OF FTE'S	ENTERED
14	NURSING ADMINISTRATION	14	NUMBER OF FTE'S	ENTERED
15	CENTRAL SERVICES & SUPPLY	15	COSTED REQUISITIONS	ENTERED
16	PHARMACY	16	COSTED REQUISITIONS	ENTERED
17	MEDICAL RECORDS & LIBRARY	17	GROSS REVENUES	ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED TIME	ENTERED

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
			0	3	4	5	5a.00	6	8
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	548,274	548,274					
004		NEW CAP REL COSTS-MVBLE E	150,114		150,114				
005		EMPLOYEE BENEFITS	1,876,483	22,712	4,000	1,903,195			
006		ADMINISTRATIVE & GENERAL	3,465,347	50,428	1,309	102,113	3,619,197	3,619,197	
008		OPERATION OF PLANT	306,032	67,473	5,629	46,264	425,398	90,664	516,062
008	01	OPERATION OF PLANT HOSP O	625,030				625,030	133,211	
008	02	OPERATION OF PLANT ANNEX	11,054				11,054	2,356	
009		LAUNDRY & LINEN SERVICE	94,706	10,097	139	16,965	121,907	25,982	12,949
010		HOUSEKEEPING	476,861	4,490		76,849	558,200	118,967	5,758
011		DIETARY	371,671	7,266	1,874	38,182	418,993	89,299	9,318
012		CAFETERIA	262,897	11,947		23,426	298,270	63,569	15,322
014		NURSING ADMINISTRATION	388,436	7,200	425	76,061	472,122	100,622	9,234
015		CENTRAL SERVICES & SUPPLY	92,346	3,258		12,794	108,398	23,103	4,178
016		PHARMACY	365,679	5,421	3,984	13,676	388,760	82,855	6,952
017		MEDICAL RECORDS & LIBRARY	378,118	10,770	15,077	60,874	464,839	99,070	13,812
020		NONPHYSICIAN ANESTHETISTS							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,239,698	38,902	1,171	234,861	1,514,632	322,809	49,892
026		INTENSIVE CARE UNIT	294,509	6,992	6,464	57,755	365,720	77,945	8,967
034		SKILLED NURSING FACILITY	209,300	17,346		40,380	267,026	56,910	22,246
035		NURSING FACILITY	1,224,009	87,275	3,114	315,754	1,630,152	347,429	111,934
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	367,573	29,972	31,844	64,214	493,603	105,200	38,439
040		ANESTHESIOLOGY	11,086				11,086	2,363	
041		RADIOLOGY-DIAGNOSTIC	1,237,904	24,617	39,157	89,973	1,391,651	296,598	31,571
042		RADIOLOGY-THERAPEUTIC	210,152				210,152	44,789	
044		LABORATORY	1,110,972	9,763	17,953	101,671	1,240,359	264,354	12,520
049		RESPIRATORY THERAPY	486,620	16,284	3,385	72,348	578,637	123,323	20,884
050		PHYSICAL THERAPY	429,606	34,309	2,084	83,381	549,380	117,088	44,001
052		SPEECH PATHOLOGY	28,454	1,029		5,723	35,206	7,503	1,320
055		MEDICAL SUPPLIES CHARGED	682,620				682,620	145,485	
056		DRUGS CHARGED TO PATIENTS	750,147				750,147	159,877	
059		OP PSYCH	585,897	21,973			607,870	129,554	28,180
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	973,092	20,029	9,000	130,432	1,132,553	241,378	25,687
062		OBSERVATION BEDS (NON-DIS							
		OTHER REIMBURS COST CNTRS							
		AMBULANCE SERVICES	167,685	5,273	929	16,003	189,890	40,471	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	19,422,372	514,826	147,538	1,679,699	19,162,852	3,312,774	473,164
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP		2,666			2,666	568	3,420
098		PHYSICIANS' PRIVATE OFFIC	1,126,295	28,187	415	218,510	1,373,407	292,710	36,150
098	01	FAYETTE COUNTY MEDICAL CE	-1	2,595	2,161		4,755	1,013	3,328
098	02	PUBLIC RELATIONS	51,936			4,986	56,922	12,132	
098	03	PERSONAL LAUNDRY							
098	04	VIS MEALS & MEALS ON WHEE							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	20,600,602	548,274	150,114	1,903,195	20,600,602	3,619,197	516,062

		COST CENTER DESCRIPTION	OPERATION OF PLANT HOSP O	OPERATION OF PLANT ANNEX	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
			8.01	8.02	9	10	11	12	14
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
008	01	OPERATION OF PLANT HOSP O	758,241						
008	02	OPERATION OF PLANT ANNEX		13,410					
009		LAUNDRY & LINEN SERVICE	20,416		181,254				
010		HOUSEKEEPING	9,078		13,432	705,435			
011		DIETARY	14,692		1,097	13,040	546,439		
012		CAFETERIA	24,158			21,441		422,760	
014		NURSING ADMINISTRATION	14,559			12,922		21,875	631,334
015		CENTRAL SERVICES & SUPPLY	6,587			5,847		6,851	
016		PHARMACY	10,961			9,728		4,775	
017		MEDICAL RECORDS & LIBRARY	21,777			19,328		18,009	
020		NONPHYSICIAN ANESTHETISTS							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	78,662		69,928	69,816	91,588	64,561	323,334
026		INTENSIVE CARE UNIT	14,138		653	12,548	7,649	11,547	57,831
034		SKILLED NURSING FACILITY	35,074			31,130	19,499	11,988	
035		NURSING FACILITY	176,476		67,686	156,633	403,804	115,212	
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	60,604		3,570	53,790		9,471	47,435
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC	49,777		3,761	44,179		22,524	
042		RADIOLOGY-THERAPEUTIC							
044		LABORATORY	19,740			17,520		28,518	
049		RESPIRATORY THERAPY	32,926		21	29,224		12,819	
050		PHYSICAL THERAPY	69,373		3,409	61,572		16,348	
052		SPEECH PATHOLOGY	2,081			1,847		960	
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS							
059		OP PSYCH		10,754		39,433	23,899		
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	40,499		8,467	35,945		34,875	174,663
062		OBSERVATION BEDS (NON-DIS							
		OTHER REIMBURS COST CNTRS							
3		AMBULANCE SERVICES				9,463		5,605	28,071
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	701,578	10,754	172,024	645,406	546,439	385,938	631,334
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP	5,392			4,785			
098		PHYSICIANS' PRIVATE OFFIC	46,023	2,656	679	50,586		33,085	
098	01	FAYETTE COUNTY MEDICAL CE	5,248			4,658			
098	02	PUBLIC RELATIONS						3,737	
098	03	PERSONAL LAUNDRY			8,551				
098	04	VIS MEALS & MEALS ON WHEE							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	758,241	13,410	181,254	705,435	546,439	422,760	631,334

		COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			15	16	17	20	25	26	27
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
008	01	OPERATION OF PLANT HOSP O							
008	02	OPERATION OF PLANT ANNEX							
009		LAUNDRY & LINEN SERVICE							
010		HOUSEKEEPING							
011		DIETARY							
012		CAFETERIA							
014		NURSING ADMINISTRATION							
015		CENTRAL SERVICES & SUPPLY	154,964						
016		PHARMACY		504,031					
017		MEDICAL RECORDS & LIBRARY			636,835				
020		NONPHYSICIAN ANESTHETISTS							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	11,790		33,054		2,630,066		2,630,066
026		INTENSIVE CARE UNIT	1,762		4,132		562,892		562,892
034		SKILLED NURSING FACILITY	1,993		4,009		449,875		449,875
035		NURSING FACILITY	12,884		38,022		3,060,232		3,060,232
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	62,970		11,260		886,342		886,342
040		ANESTHESIOLOGY	1,292		7,164		21,905		21,905
041		RADIOLOGY-DIAGNOSTIC	3,293		110,714		1,954,068		1,954,068
042		RADIOLOGY-THERAPEUTIC	3		10,996		265,940		265,940
044		LABORATORY	6,414		125,424		1,714,849		1,714,849
049		RESPIRATORY THERAPY	1,255		44,973		844,062		844,062
050		PHYSICAL THERAPY	712		16,668		878,551		878,551
052		SPEECH PATHOLOGY	10		766		49,693		49,693
055		MEDICAL SUPPLIES CHARGED	34,933		30,303		893,341		893,341
056		DRUGS CHARGED TO PATIENTS	2,102	504,031	96,772		1,512,929		1,512,929
059		OP PSYCH	47		19,612		859,349		859,349
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	7,979		45,266		1,747,312		1,747,312
062		OBSERVATION BEDS (NON-DIS							
		OTHER REIMBURS COST CNTRS							
5		AMBULANCE SERVICES	1,078		17,732		292,310		292,310
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	150,517	504,031	616,867		18,623,716		18,623,716
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP					16,831		16,831
098		PHYSICIANS' PRIVATE OFFIC	4,447		19,968		1,859,711		1,859,711
098	01	FAYETTE COUNTY MEDICAL CE					19,002		19,002
098	02	PUBLIC RELATIONS					72,791		72,791
098	03	PERSONAL LAUNDRY					8,551		8,551
098	04	VIS MEALS & MEALS ON WHEE							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	154,964	504,031	636,835		20,600,602		20,600,602

ALLOCATION OF OLD CAPITAL RELATED COSTS

PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIR ASSGNED OLD CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
		0	3	4	4a	5	6	8
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	67			67		67	
008	OPERATION OF PLANT						2	2
008 01	OPERATION OF PLANT HOSP O						3	
008 02	OPERATION OF PLANT ANNEX							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING						2	
011	DIETARY						2	
012	CAFETERIA						1	
014	NURSING ADMINISTRATION						2	
015	CENTRAL SERVICES & SUPPLY							
016	PHARMACY						2	
017	MEDICAL RECORDS & LIBRARY						2	
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS						6	
026	INTENSIVE CARE UNIT						1	
034	SKILLED NURSING FACILITY						1	
035	NURSING FACILITY						6	2
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM						2	
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC						6	
042	RADIOLOGY-THERAPEUTIC						1	
044	LABORATORY						5	
049	RESPIRATORY THERAPY						2	
050	PHYSICAL THERAPY						2	
052	SPEECH PATHOLOGY							
055	MEDICAL SUPPLIES CHARGED						3	
056	DRUGS CHARGED TO PATIENTS						3	
059	OP PSYCH						2	
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY						5	
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
;	AMBULANCE SERVICES						1	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	67			67		62	2
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
098	PHYSICIANS' PRIVATE OFFIC						5	
098 01	FAYETTE COUNTY MEDICAL CE							
098 02	PUBLIC RELATIONS							
098 03	PERSONAL LAUNDRY							
098 04	VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	67			67		67	2

		COST CENTER DESCRIPTION	OPERATION OF PLANT HOSP O	OPERATION OF PLANT ANNEX	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
			8.01	8.02	9	10	11	12	14
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
008	01	OPERATION OF PLANT HOSP O	3						
008	02	OPERATION OF PLANT ANNEX							
009		LAUNDRY & LINEN SERVICE							
010		HOUSEKEEPING				2			
011		DIETARY					2		
012		CAFETERIA						1	
014		NURSING ADMINISTRATION							2
015		CENTRAL SERVICES & SUPPLY							
016		PHARMACY							
017		MEDICAL RECORDS & LIBRARY							
020		NONPHYSICIAN ANESTHETISTS							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS							1
026		INTENSIVE CARE UNIT							
034		SKILLED NURSING FACILITY							
035		NURSING FACILITY	3			2	2	1	
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM							
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC							
042		RADIOLOGY-THERAPEUTIC							
044		LABORATORY							
049		RESPIRATORY THERAPY							
050		PHYSICAL THERAPY							
052		SPEECH PATHOLOGY							
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS							
059		OP PSYCH							
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY							1
062		OBSERVATION BEDS (NON-DIS							
		OTHER REIMBURS COST CNTRS							
		AMBULANCE SERVICES							
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	3			2	2	1	2
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC							
098	01	FAYETTE COUNTY MEDICAL CE							
098	02	PUBLIC RELATIONS							
098	03	PERSONAL LAUNDRY							
098	04	VIS MEALS & MEALS ON WHEE							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	3			2	2	1	2

	COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		15	16	17	25	26	27
	GENERAL SERVICE COST CNTR						
003	NEW CAP REL COSTS-BLDG &						
004	NEW CAP REL COSTS-MVBLE E						
005	EMPLOYEE BENEFITS						
006	ADMINISTRATIVE & GENERAL						
008	OPERATION OF PLANT						
008 01	OPERATION OF PLANT HOSP O						
008 02	OPERATION OF PLANT ANNEX						
009	LAUNDRY & LINEN SERVICE						
010	HOUSEKEEPING						
011	DIETARY						
012	CAFETERIA						
014	NURSING ADMINISTRATION						
015	CENTRAL SERVICES & SUPPLY						
016	PHARMACY		2				
017	MEDICAL RECORDS & LIBRARY			2			
020	NONPHYSICIAN ANESTHETISTS						
	INPAT ROUTINE SRVC CNTRS						
025	ADULTS & PEDIATRICS				7		7
026	INTENSIVE CARE UNIT				1		1
034	SKILLED NURSING FACILITY				1		1
035	NURSING FACILITY				16		16
	ANCILLARY SRVC COST CNTRS						
037	OPERATING ROOM				2		2
040	ANESTHESIOLOGY						
041	RADIOLOGY-DIAGNOSTIC				6		6
042	RADIOLOGY-THERAPEUTIC				1		1
044	LABORATORY			2	7		7
049	RESPIRATORY THERAPY				2		2
050	PHYSICAL THERAPY				2		2
052	SPEECH PATHOLOGY						
055	MEDICAL SUPPLIES CHARGED				3		3
056	DRUGS CHARGED TO PATIENTS		2		5		5
059	OP PSYCH				2		2
	OUTPAT SERVICE COST CNTRS						
061	EMERGENCY				6		6
062	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
	AMBULANCE SERVICES				1		1
	SPEC PURPOSE COST CENTERS						
095	SUBTOTALS		2	2	62		62
	NONREIMBURS COST CENTERS						
096	GIFT, FLOWER, COFFEE SHOP						
098	PHYSICIANS' PRIVATE OFFIC				5		5
098 01	FAYETTE COUNTY MEDICAL CE						
098 02	PUBLIC RELATIONS						
098 03	PERSONAL LAUNDRY						
098 04	VIS MEALS & MEALS ON WHEE						
101	CROSS FOOT ADJUSTMENTS						
102	NEGATIVE COST CENTER						
103	TOTAL		2	2	67		67

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET B I PART III

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
		0	3	4	4a	5	6	8
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS	1,238	22,712	4,000	27,950	27,950		
006	ADMINISTRATIVE & GENERAL	153,764	50,428	1,309	205,501	1,500	207,001	
008	OPERATION OF PLANT	3,170	67,473	5,629	76,272	680	5,186	82,138
008 01	OPERATION OF PLANT HOSP O						7,619	
008 02	OPERATION OF PLANT ANNEX						135	
009	LAUNDRY & LINEN SERVICE		10,097	139	10,236	249	1,486	2,061
010	HOUSEKEEPING		4,490		4,490	1,129	6,804	916
011	DIETARY	707	7,266	1,874	9,847	561	5,108	1,483
012	CAFETERIA		11,947		11,947	344	3,636	2,439
014	NURSING ADMINISTRATION	2,710	7,200	425	10,335	1,117	5,755	1,470
015	CENTRAL SERVICES & SUPPLY	17,704	3,258		20,962	188	1,321	665
016	PHARMACY	51,960	5,421	3,984	61,365	201	4,739	1,106
017	MEDICAL RECORDS & LIBRARY	1,459	10,770	15,077	27,306	894	5,666	2,198
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		38,902	1,171	40,073	3,450	18,463	7,941
026	INTENSIVE CARE UNIT		6,992	6,464	13,456	848	4,458	1,427
034	SKILLED NURSING FACILITY		17,346		17,346	593	3,255	3,541
035	NURSING FACILITY		87,275	3,114	90,389	4,634	19,870	17,817
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		29,972	31,844	61,816	943	6,017	6,118
040	ANESTHESIOLOGY						135	
041	RADIOLOGY-DIAGNOSTIC	1,718	24,617	39,157	65,492	1,321	16,964	5,025
042	RADIOLOGY-THERAPEUTIC						2,562	
044	LABORATORY	2,034	9,763	17,953	29,750	1,493	15,120	1,993
049	RESPIRATORY THERAPY	14,120	16,284	3,385	33,789	1,063	7,054	3,324
050	PHYSICAL THERAPY		34,309	2,084	36,393	1,225	6,697	7,003
052	SPEECH PATHOLOGY		1,029		1,029	84	429	210
055	MEDICAL SUPPLIES CHARGED						8,321	
056	DRUGS CHARGED TO PATIENTS						9,144	
059	OP PSYCH	1,441	21,973		23,414		7,410	4,485
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	1,459	20,029	9,000	30,488	1,916	13,806	4,088
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
	AMBULANCE SERVICES		5,273	929	6,202	235	2,315	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	253,484	514,826	147,538	915,848	24,668	189,475	75,310
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		2,666		2,666		32	544
098	PHYSICIANS' PRIVATE OFFIC		28,187	415	28,602	3,209	16,742	5,754
098 01	FAYETTE COUNTY MEDICAL CE		2,595	2,161	4,756		58	530
098 02	PUBLIC RELATIONS					73	694	
098 03	PERSONAL LAUNDRY							
098 04	VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	253,484	548,274	150,114	951,872	27,950	207,001	82,138

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET B PART III

		COST CENTER DESCRIPTION	OPERATION OF PLANT HOSP O	OPERATION OF PLANT ANNEX	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
			8.01	8.02	9	10	11	12	14
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
008	01	OPERATION OF PLANT HOSP O	7,619						
008	02	OPERATION OF PLANT ANNEX		135					
009		LAUNDRY & LINEN SERVICE	205		14,237				
010		HOUSEKEEPING	91		1,055	14,485			
011		DIETARY	148		86	268	17,501		
012		CAFETERIA	243			440		19,049	
014		NURSING ADMINISTRATION	146			265		986	20,074
015		CENTRAL SERVICES & SUPPLY	66			120		309	
016		PHARMACY	110			200		215	
017		MEDICAL RECORDS & LIBRARY	219			397		811	
020		NONPHYSICIAN ANESTHETISTS							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	790		5,493	1,434	2,933	2,909	10,280
026		INTENSIVE CARE UNIT	142		51	258	245	520	1,839
034		SKILLED NURSING FACILITY	352			639	625	540	
035		NURSING FACILITY	1,775		5,317	3,216	12,933	5,191	
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	609		280	1,104		427	1,508
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC	500		295	907		1,015	
042		RADIOLOGY-THERAPEUTIC							
044		LABORATORY	198			360		1,285	
049		RESPIRATORY THERAPY	331		2	600		578	
050		PHYSICAL THERAPY	697		268	1,264		737	
052		SPEECH PATHOLOGY	21			38		43	
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS							
059		OP PSYCH		108		810	765		
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	407		665	738		1,571	5,554
062		OBSERVATION BEDS (NON-DIS							
		OTHER REIMBURS COST CNTRS							
5		AMBULANCE SERVICES				194		253	893
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	7,050	108	13,512	13,252	17,501	17,390	20,074
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP	54			98			
098		PHYSICIANS' PRIVATE OFFIC	462	27	53	1,039		1,491	
098	01	FAYETTE COUNTY MEDICAL CE	53			96			
098	02	PUBLIC RELATIONS						168	
098	03	PERSONAL LAUNDRY			672				
098	04	VIS MEALS & MEALS ON WHEE							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	7,619	135	14,237	14,485	17,501	19,049	20,074

	COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		15	16	17	20	25	26	27
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
008 01	OPERATION OF PLANT HOSP O							
008 02	OPERATION OF PLANT ANNEX							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING							
011	DIETARY							
012	CAFETERIA							
014	NURSING ADMINISTRATION							
015	CENTRAL SERVICES & SUPPLY	23,631						
016	PHARMACY		67,936					
017	MEDICAL RECORDS & LIBRARY			37,491				
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,798		1,945		97,509		97,509
026	INTENSIVE CARE UNIT	269		243		23,756		23,756
034	SKILLED NURSING FACILITY	304		236		27,431		27,431
035	NURSING FACILITY	1,965		2,238		165,345		165,345
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	9,604		663		89,089		89,089
040	ANESTHESIOLOGY	197		422		754		754
041	RADIOLOGY-DIAGNOSTIC	502		6,516		98,537		98,537
042	RADIOLOGY-THERAPEUTIC			647		3,209		3,209
044	LABORATORY	978		7,391		58,568		58,568
049	RESPIRATORY THERAPY	191		2,647		49,579		49,579
050	PHYSICAL THERAPY	109		981		55,374		55,374
052	SPEECH PATHOLOGY	1		45		1,900		1,900
055	MEDICAL SUPPLIES CHARGED	5,327		1,784		15,432		15,432
056	DRUGS CHARGED TO PATIENTS	320	67,936	5,696		83,096		83,096
059	OP PSYCH	7		1,154		38,153		38,153
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	1,217		2,664		63,114		63,114
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
5	AMBULANCE SERVICES	164		1,044		11,300		11,300
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	22,953	67,936	36,316		882,146		882,146
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP					3,394		3,394
098	PHYSICIANS' PRIVATE OFFIC	678		1,175		59,232		59,232
098 01	FAYETTE COUNTY MEDICAL CE					5,493		5,493
098 02	PUBLIC RELATIONS					935		935
098 03	PERSONAL LAUNDRY					672		672
098 04	VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	23,631	67,936	37,491		951,872		951,872

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE E (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQ FT)
		3	4	5	6a.00	6	8
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	100,135					
004	NEW CAP REL COSTS-MVB		450,341				
005	EMPLOYEE BENEFITS	4,148	12,000	8,965,217			
006	ADMINISTRATIVE & GENE	9,210	3,928	481,015	-3,619,197	16,981,405	
008	OPERATION OF PLANT	12,323	16,887	217,932		425,398	73,491
008 01	OPERATION OF PLANT HO					625,030	
008 02	OPERATION OF PLANT AN					11,054	
009	LAUNDRY & LINEN SERVI	1,844	416	79,914		121,907	1,844
010	HOUSEKEEPING	820		362,007		558,200	820
011	DIETARY	1,327	5,621	179,860		418,993	1,327
012	CAFETERIA	2,182		110,350		298,270	2,182
014	NURSING ADMINISTRATIO	1,315	1,274	358,292		472,122	1,315
015	CENTRAL SERVICES & SU	595		60,268		108,398	595
016	PHARMACY	990	11,951	64,420		388,760	990
017	MEDICAL RECORDS & LIB	1,967	45,231	286,751		464,839	1,967
020	NONPHYSICIAN ANESTHET						
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	7,105	3,512	1,106,335		1,514,632	7,105
026	INTENSIVE CARE UNIT	1,277	19,392	272,059		365,720	1,277
034	SKILLED NURSING FACIL	3,168		190,214		267,026	3,168
035	NURSING FACILITY	15,940	9,343	1,487,427		1,630,152	15,940
	ANCILLARY SRVC COST C						
037	OPERATING ROOM	5,474	95,533	302,488		493,603	5,474
040	ANESTHESIOLOGY					11,086	
041	RADIOLOGY-DIAGNOSTIC	4,496	117,473	423,828		1,391,651	4,496
042	RADIOLOGY-THERAPEUTIC					210,152	
044	LABORATORY	1,783	53,859	478,931		1,240,359	1,783
049	RESPIRATORY THERAPY	2,974	10,155	340,802		578,637	2,974
050	PHYSICAL THERAPY	6,266	6,252	392,773		549,380	6,266
052	SPEECH PATHOLOGY	188		26,958		35,206	188
055	MEDICAL SUPPLIES CHAR					682,620	
056	DRUGS CHARGED TO PATI					750,147	
079	OP PSYCH	4,013				607,870	4,013
	OUTPAT SERVICE COST C						
061	EMERGENCY	3,658	27,001	614,412		1,132,553	3,658
062	OBSERVATION BEDS (NON						
	OTHER REIMBURS COST C					189,890	
065	AMBULANCE SERVICES	963	2,786	75,382			
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	94,026	442,614	7,912,418	-3,619,197	15,543,655	67,382
	NONREIMBURS COST CENT						
096	GIFT, FLOWER, COFFEE	487				2,666	487
098	PHYSICIANS' PRIVATE O	5,148	1,245	1,029,312		1,373,407	5,148
098 01	FAYETTE COUNTY MEDICA	474	6,482			4,755	474
098 02	PUBLIC RELATIONS			23,487		56,922	
098 03	PERSONAL LAUNDRY						
098 04	VIS MEALS & MEALS ON						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	548,274	150,114	1,903,195		3,619,197	516,062
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	5.475348	.333334	.212287		.213127	7.022112
105	COST TO BE ALLOCATED (WRKSHT B, PART II)					67	2
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)					.000004	.000027
107	COST TO BE ALLOCATED (WRKSHT B, PART III			27,950		207,001	82,138
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)			.003118		.012190	1.117661

	COST CENTER DESCRIPTION	OPERATION OF PLANT HOSP O (SQ FT)	OPERATION OF PLANT ANNEX (SQUARE FEET)	LAUNDRY & LIN EN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMIN ISTRATION (NUMBER OF FTE'S)
		8.01	8.02	9	10	11	12	14
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
008	OPERATION OF PLANT							
008 01	OPERATION OF PLANT HO	68,487						
008 02	OPERATION OF PLANT AN		5,004					
009	LAUNDRY & LINEN SERVI	1,844		572,066				
010	HOUSEKEEPING	820		42,393	71,790			
011	DIETARY	1,327		3,463	1,327	93,151		
012	CAFETERIA	2,182			2,182		16,292	
014	NURSING ADMINISTRATIO	1,315			1,315		843	4,858
015	CENTRAL SERVICES & SU	595			595		264	
016	PHARMACY	990			990		184	
017	MEDICAL RECORDS & LIB	1,967			1,967		694	
020	NONPHYSICIAN ANESTHET							
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	7,105		220,707	7,105	15,613	2,488	2,488
026	INTENSIVE CARE UNIT	1,277		2,060	1,277	1,304	445	445
034	SKILLED NURSING FACIL	3,168			3,168	3,324	462	
035	NURSING FACILITY	15,940		213,627	15,940	68,836	4,440	
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	5,474		11,267	5,474		365	365
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	4,496		11,870	4,496		868	
042	RADIOLOGY-THERAPEUTIC							
044	LABORATORY	1,783			1,783		1,099	
049	RESPIRATORY THERAPY	2,974		65	2,974		494	
050	PHYSICAL THERAPY	6,266		10,759	6,266		630	
052	SPEECH PATHOLOGY	188			188		37	
055	MEDICAL SUPPLIES CHAR							
056	DRUGS CHARGED TO PATI							
[illegible]	OP PSYCH		4,013		4,013	4,074		
	OUTPAT SERVICE COST C							
[illegible]	EMERGENCY	3,658		26,724	3,658		1,344	1,344
062	OBSERVATION BEDS (NON							
	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES				963		216	216
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	63,369	4,013	542,935	65,681	93,151	14,873	4,858
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE	487			487			
098	PHYSICIANS' PRIVATE O	4,157	991	2,143	5,148		1,275	
098 01	FAYETTE COUNTY MEDICA	474			474			
098 02	PUBLIC RELATIONS						144	
098 03	PERSONAL LAUNDRY			26,988				
098 04	VIS MEALS & MEALS ON							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	758,241	13,410	181,254	705,435	546,439	422,760	631,334
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	11.071313	2.679856	.316841	9.826369	5.866164	25.948932	129.957596
105	COST TO BE ALLOCATED (WRKSHT B, PART II)	3			2	2	1	2
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)	.000044			.000028	.000021	.000061	.000412
107	COST TO BE ALLOCATED (WRKSHT B, PART III	7,619	135	14,237	14,485	17,501	19,049	20,074
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.111247	.026978	.024887	.201769	.187878	1.169224	4.132153

	COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)
		15	16	17	20
	GENERAL SERVICE COST				
003	NEW CAP REL COSTS-BLD				
004	NEW CAP REL COSTS-MVB				
005	EMPLOYEE BENEFITS				
006	ADMINISTRATIVE & GENE				
008	OPERATION OF PLANT				
008 01	OPERATION OF PLANT HO				
008 02	OPERATION OF PLANT AN				
009	LAUNDRY & LINEN SERVI				
010	HOUSEKEEPING				
011	DIETARY				
012	CAFETERIA				
014	NURSING ADMINISTRATIO				
015	CENTRAL SERVICES & SU	664,865			
016	PHARMACY		100		
017	MEDICAL RECORDS & LIB			52,274,990	
020	NONPHYSICIAN ANESTHET				100
	INPAT ROUTINE SRVC CN				
025	ADULTS & PEDIATRICS	50,584		2,713,373	
026	INTENSIVE CARE UNIT	7,561		339,214	
034	SKILLED NURSING FACIL	8,550		329,101	
035	NURSING FACILITY	55,276		3,121,165	
	ANCILLARY SRVC COST C				
037	OPERATING ROOM	270,179		924,304	
040	ANESTHESIOLOGY	5,542		588,116	100
041	RADIOLOGY-DIAGNOSTIC	14,128		9,088,335	
042	RADIOLOGY-THERAPEUTIC	11		902,641	
044	LABORATORY	27,518		10,293,912	
049	RESPIRATORY THERAPY	5,384		3,691,770	
050	PHYSICAL THERAPY	3,055		1,368,254	
052	SPEECH PATHOLOGY	42		62,894	
055	MEDICAL SUPPLIES CHAR	149,879		2,487,551	
056	DRUGS CHARGED TO PATI	9,017	100	7,943,848	
059	OP PSYCH	200		1,609,955	
	OUTPAT SERVICE COST C				
061	EMERGENCY	34,235		3,715,819	
062	OBSERVATION BEDS (NON				
	OTHER REIMBURS COST C				
065	AMBULANCE SERVICES	4,623		1,455,595	
	SPEC PURPOSE COST CEN				
095	SUBTOTALS	645,784	100	50,635,847	100
	NONREIMBURS COST CENT				
096	GIFT, FLOWER, COFFEE				
098	PHYSICIANS' PRIVATE O	19,081		1,639,143	
098 01	FAYETTE COUNTY MEDICA				
098 02	PUBLIC RELATIONS				
098 03	PERSONAL LAUNDRY				
098 04	VIS MEALS & MEALS ON				
101	CROSS FOOT ADJUSTMENT				
102	NEGATIVE COST CENTER				
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	154,964	504,031	636,835	
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	.233076	5,040.310000	.012182	
105	COST TO BE ALLOCATED (PER WRKSHT B, PART		2	2	
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)		.020000		
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	23,631	67,936	37,491	
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.035543	679.360000	.000717	

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET C PART I

WKST A LTNE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,630,066		2,630,066		2,630,066
26	INTENSIVE CARE UNIT	562,892		562,892		562,892
34	SKILLED NURSING FACILITY	449,875		449,875		449,875
35	NURSING FACILITY	3,060,232		3,060,232		3,060,232
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	886,342		886,342		886,342
40	ANESTHESIOLOGY	21,905		21,905		21,905
41	RADIOLOGY-DIAGNOSTIC	1,954,068		1,954,068		1,954,068
42	RADIOLOGY-THERAPEUTIC	265,940		265,940		265,940
44	LABORATORY	1,714,849		1,714,849		1,714,849
49	RESPIRATORY THERAPY	844,062		844,062		844,062
50	PHYSICAL THERAPY	878,551		878,551		878,551
52	SPEECH PATHOLOGY	49,693		49,693		49,693
55	MEDICAL SUPPLIES CHARGED	893,341		893,341		893,341
56	DRUGS CHARGED TO PATIENTS	1,512,929		1,512,929		1,512,929
59	OP PSYCH	859,349		859,349		859,349
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,747,312		1,747,312		1,747,312
62	OBSERVATION BEDS (NON-DIS	271,334		271,334		271,334
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	292,310		292,310		292,310
101	SUBTOTAL	18,895,050		18,895,050		18,895,050
102	LESS OBSERVATION BEDS	271,334		271,334		271,334
103	TOTAL	18,623,716		18,623,716		18,623,716

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,354,558		2,354,558			
26	INTENSIVE CARE UNIT	339,214		339,214			
34	SKILLED NURSING FACILITY	329,101		329,101			
35	NURSING FACILITY	3,121,165		3,121,165			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	99,113	825,191	924,304	.958929	.958929	.958929
40	ANESTHESIOLOGY	56,123	436,746	492,869	.044444	.044444	.044444
41	RADIOLOGY-DIAGNOSTIC	1,119,888	7,968,447	9,088,335	.215008	.215008	.215008
42	RADIOLOGY-THERAPEUTIC	97,405	805,236	902,641	.294624	.294624	.294624
44	LABORATORY	2,384,536	7,909,377	10,293,913	.166589	.166589	.166589
49	RESPIRATORY THERAPY	1,516,403	1,285,762	2,802,165	.301218	.301218	.301218
50	PHYSICAL THERAPY	503,016	865,238	1,368,254	.642096	.642096	.642096
52	SPEECH PATHOLOGY	16,152	46,742	62,894	.790107	.790107	.790107
55	MEDICAL SUPPLIES CHARGED	1,652,273	1,533,345	3,185,618	.280429	.280429	.280429
56	DRUGS CHARGED TO PATIENTS	5,664,829	2,279,019	7,943,848	.190453	.190453	.190453
59	OP PSYCH		1,609,955	1,609,955	.533772	.533772	.533772
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	129,735	3,586,084	3,715,819	.470236	.470236	.470236
62	OBSERVATION BEDS (NON-DIS	43,753	315,062	358,815	.756195	.756195	.756195
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,455,595	1,455,595	.200818	.200818	.200818
101	SUBTOTAL	19,427,264	30,921,799	50,349,063			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,427,264	30,921,799	50,349,063			

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL **NOT A CMS WORKSHEET ** (07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,630,066		2,630,066		2,630,066
26	INTENSIVE CARE UNIT	562,892		562,892		562,892
34	SKILLED NURSING FACILITY	449,875		449,875		449,875
35	NURSING FACILITY	3,060,232		3,060,232		3,060,232
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	886,342		886,342		886,342
40	ANESTHESIOLOGY	21,905		21,905		21,905
41	RADIOLOGY-DIAGNOSTIC	1,954,068		1,954,068		1,954,068
42	RADIOLOGY-THERAPEUTIC	265,940		265,940		265,940
44	LABORATORY	1,714,849		1,714,849		1,714,849
49	RESPIRATORY THERAPY	844,062		844,062		844,062
50	PHYSICAL THERAPY	878,551		878,551		878,551
52	SPEECH PATHOLOGY	49,693		49,693		49,693
55	MEDICAL SUPPLIES CHARGED	893,341		893,341		893,341
56	DRUGS CHARGED TO PATIENTS	1,512,929		1,512,929		1,512,929
59	OP PSYCH	859,349		859,349		859,349
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,747,312		1,747,312		1,747,312
62	OBSERVATION BEDS (NON-DIS	271,334		271,334		271,334
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	292,310		292,310		292,310
101	SUBTOTAL	18,895,050		18,895,050		18,895,050
102	LESS OBSERVATION BEDS	271,334		271,334		271,334
103	TOTAL	18,623,716		18,623,716		18,623,716

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL **NOT A CMS WORKSHEET ** (07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,354,558		2,354,558			
26	INTENSIVE CARE UNIT	339,214		339,214			
34	SKILLED NURSING FACILITY	329,101		329,101			
35	NURSING FACILITY	3,121,165		3,121,165			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	99,113	825,191	924,304	.958929	.958929	.958929
40	ANESTHESIOLOGY	56,123	436,746	492,869	.044444	.044444	.044444
41	RADIOLOGY-DIAGNOSTIC	1,119,888	7,968,447	9,088,335	.215008	.215008	.215008
42	RADIOLOGY-THERAPEUTIC	97,405	805,236	902,641	.294624	.294624	.294624
44	LABORATORY	2,384,536	7,909,377	10,293,913	.166589	.166589	.166589
49	RESPIRATORY THERAPY	1,516,403	1,285,762	2,802,165	.301218	.301218	.301218
50	PHYSICAL THERAPY	503,016	865,238	1,368,254	.642096	.642096	.642096
52	SPEECH PATHOLOGY	16,152	46,742	62,894	.790107	.790107	.790107
55	MEDICAL SUPPLIES CHARGED	1,652,273	1,533,345	3,185,618	.280429	.280429	.280429
56	DRUGS CHARGED TO PATIENTS	5,664,829	2,279,019	7,943,848	.190453	.190453	.190453
59	OP PSYCH		1,609,955	1,609,955	.533772	.533772	.533772
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	129,735	3,586,084	3,715,819	.470236	.470236	.470236
62	OBSERVATION BEDS (NON-DIS	43,753	315,062	358,815	.756195	.756195	.756195
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,455,595	1,455,595	.200818	.200818	.200818
101	SUBTOTAL	19,427,264	30,921,799	50,349,063			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,427,264	30,921,799	50,349,063			

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET C PART II

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	886,342	89,091	797,251			886,342
40	ANESTHESIOLOGY	21,905	754	21,151			21,905
41	RADIOLOGY-DIAGNOSTIC	1,954,068	98,543	1,855,525			1,954,068
42	RADIOLOGY-THERAPEUTIC	265,940	3,210	262,730			265,940
44	LABORATORY	1,714,849	58,575	1,656,274			1,714,849
49	RESPIRATORY THERAPY	844,062	49,581	794,481			844,062
50	PHYSICAL THERAPY	878,551	55,376	823,175			878,551
52	SPEECH PATHOLOGY	49,693	1,900	47,793			49,693
55	MEDICAL SUPPLIES CHARGED	893,341	15,435	877,906			893,341
56	DRUGS CHARGED TO PATIENTS	1,512,929	83,101	1,429,828			1,512,929
59	OP PSYCH	859,349	38,155	821,194			859,349
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	1,747,312	63,120	1,684,192			1,747,312
62	OBSERVATION BEDS (NON-DIS	271,334		271,334			271,334
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	292,310	11,301	281,009			292,310
101	SUBTOTAL	12,191,985	568,142	11,623,843			12,191,985
102	LESS OBSERVATION BEDS	271,334		271,334			271,334
103	TOTAL	11,920,651	568,142	11,352,509			11,920,651

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C I PART II

WKST A E	NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
	37	OPERATING ROOM	924,304	.958929	.958929
	40	ANESTHESIOLOGY	492,869	.044444	.044444
	41	RADIOLOGY-DIAGNOSTIC	9,088,335	.215008	.215008
	42	RADIOLOGY-THERAPEUTIC	902,641	.294624	.294624
	44	LABORATORY	10,293,913	.166589	.166589
	49	RESPIRATORY THERAPY	2,802,165	.301218	.301218
	50	PHYSICAL THERAPY	1,368,254	.642096	.642096
	52	SPEECH PATHOLOGY	62,894	.790107	.790107
	55	MEDICAL SUPPLIES CHARGED	3,185,618	.280429	.280429
	56	DRUGS CHARGED TO PATIENTS	7,943,848	.190453	.190453
	59	OP PSYCH	1,609,955	.533772	.533772
		OUTPAT SERVICE COST CNTRS			
	61	EMERGENCY	3,715,819	.470236	.470236
	62	OBSERVATION BEDS (NON-DIS	358,815	.756195	.756195
		OTHER REIMBURS COST CNTRS			
	65	AMBULANCE SERVICES	1,455,595	.200818	.200818
	101	SUBTOTAL	44,205,025		
	102	LESS OBSERVATION BEDS	358,815		
	103	TOTAL	43,846,210		

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1346 PERIOD: FROM 1/ 1/2009 TO 12/31/2009

PREPARED 5/20/2010 WORKSHEET C PART II

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	886,342	89,091	797,251			886,342
40	ANESTHESIOLOGY	21,905	754	21,151			21,905
41	RADIOLOGY-DIAGNOSTIC	1,954,068	98,543	1,855,525			1,954,068
42	RADIOLOGY-THERAPEUTIC	265,940	3,210	262,730			265,940
44	LABORATORY	1,714,849	58,575	1,656,274			1,714,849
49	RESPIRATORY THERAPY	844,062	49,581	794,481			844,062
50	PHYSICAL THERAPY	878,551	55,376	823,175			878,551
52	SPEECH PATHOLOGY	49,693	1,900	47,793			49,693
55	MEDICAL SUPPLIES CHARGED	893,341	15,435	877,906			893,341
56	DRUGS CHARGED TO PATIENTS	1,512,929	83,101	1,429,828			1,512,929
59	OP PSYCH	859,349	38,155	821,194			859,349
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	1,747,312	63,120	1,684,192			1,747,312
62	OBSERVATION BEDS (NON-DIS	271,334		271,334			271,334
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	292,310	11,301	281,009			292,310
101	SUBTOTAL	12,191,985	568,142	11,623,843			12,191,985
102	LESS OBSERVATION BEDS	271,334		271,334			271,334
103	TOTAL	11,920,651	568,142	11,352,509			11,920,651

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1346 PERIOD: FROM 1/ 1/2009 TO 12/31/2009

PREPARED 5/20/2010 WORKSHEET C PART II

WKST A NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	924,304	.958929	.958929
40	ANESTHESIOLOGY	492,869	.044444	.044444
41	RADIOLOGY-DIAGNOSTIC	9,088,335	.215008	.215008
42	RADIOLOGY-THERAPEUTIC	902,641	.294624	.294624
44	LABORATORY	10,293,913	.166589	.166589
49	RESPIRATORY THERAPY	2,802,165	.301218	.301218
50	PHYSICAL THERAPY	1,368,254	.642096	.642096
52	SPEECH PATHOLOGY	62,894	.790107	.790107
55	MEDICAL SUPPLIES CHARGED	3,185,618	.280429	.280429
56	DRUGS CHARGED TO PATIENTS	7,943,848	.190453	.190453
59	OP PSYCH	1,609,955	.533772	.533772
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	3,715,819	.470236	.470236
62	OBSERVATION BEDS (NON-DIS	358,815	.756195	.756195
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,455,595	.200818	.200818
101	SUBTOTAL	44,205,025		
102	LESS OBSERVATION BEDS	358,815		
103	TOTAL	43,846,210		

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL

IN LIEU OF FORM CMS-2552-96(09/1997)

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C PART III

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,278,542	1,027,142			
40	ANESTHESIOLOGY	54,351	377,448			
41	RADIOLOGY-DIAGNOSTIC	1,890,778	7,918,205			
42	RADIOLOGY-THERAPEUTIC	333,624	1,144,001			
44	LABORATORY	1,868,508	9,925,195			
49	RESPIRATORY THERAPY	974,442	2,701,358			
50	PHYSICAL THERAPY	905,250	1,310,689			
52	SPEECH PATHOLOGY	50,801	89,539			
55	MEDICAL SUPPLIES CHARGED	474,819	3,928,070			
56	DRUGS CHARGED TO PATIENTS	1,593,308	8,195,753			
59	OP PSYCH	793,096	1,540,591			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,799,002	3,916,136			
62	OBSERVATION BEDS (NON-DIS	260,143	279,963			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	316,626	1,359,024			
101	TOTAL	12,593,290	43,713,114			

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL

IN LIEU OF FORM CMS-2552-96(09/1996)

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C I PART V

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT-PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	1,278,542		1,278,542	1,027,142			
40	ANESTHESIOLOGY	54,351		54,351	377,448			
41	RADIOLOGY-DIAGNOSTIC	1,890,778		1,890,778	7,918,205			
42	RADIOLOGY-THERAPEUTIC	333,624		333,624	1,144,001			
44	LABORATORY	1,868,508	27,083	1,895,591	9,925,195			
49	RESPIRATORY THERAPY	974,442		974,442	2,701,358			
50	PHYSICAL THERAPY	905,250		905,250	1,310,689			
52	SPEECH PATHOLOGY	50,801		50,801	89,539			
55	MEDICAL SUPPLIES CHARGED	474,819		474,819	3,928,070			
56	DRUGS CHARGED TO PATIENTS	1,593,308		1,593,308	8,195,753			
59	OP PSYCH	793,096		793,096	1,540,591			
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY	1,799,002	653,354	2,452,356	3,916,136			
62	OBSERVATION BEDS (NON-DIS	260,143		260,143	279,963			
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES	316,626		316,626	1,359,024			
101	TOTAL	12,593,290	680,437	13,273,727	43,713,114			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010
I COMPONENT NO: 14-1346 I WORKSHEET D PART V

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9) 1	Cost/Charge Ratio (C, Pt I, col. 9) 1.01	Cost/Charge Ratio (C, Pt II, col. 9) 1.02	Outpatient Ambulatory Surgical Ctr 2	Outpatient Radialogy 3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.958929		.958929		
40	ANESTHESIOLOGY	.044444		.044444		
41	RADIOLOGY-DIAGNOSTIC	.215008		.215008		
42	RADIOLOGY-THERAPEUTIC	.294624		.294624		
44	LABORATORY	.166589		.166589		
49	RESPIRATORY THERAPY	.301218		.301218		
50	PHYSICAL THERAPY	.642096		.642096		
52	SPEECH PATHOLOGY	.790107		.790107		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.280429		.280429		
56	DRUGS CHARGED TO PATIENTS	.190453		.190453		
59	OP PSYCH	.533772		.533772		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.470236		.470236		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.756195		.756195		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.200818		.200818		
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART V
14-1346		

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic
		4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		405,710			
40	ANESTHESIOLOGY		90,591			
41	RADIOLOGY-DIAGNOSTIC		3,036,432			
42	RADIOLOGY-THERAPEUTIC		474,825			
44	LABORATORY		3,804,342			
49	RESPIRATORY THERAPY		982,671			
50	PHYSICAL THERAPY		303,907			
52	SPEECH PATHOLOGY		3,162			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		751,393			
56	DRUGS CHARGED TO PATIENTS		976,448			
59	OP PSYCH		1,575,867			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		996,505			
62	OBSERVATION BEDS (NON-DISTINCT PART)		188,945			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		13,590,798			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		13,590,798			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED	5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D	
COMPONENT NO:	TO 12/31/2009	PART V	
14-1346			

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	All Other 9	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	389,047		
40	ANESTHESIOLOGY	4,026		
41	RADIOLOGY-DIAGNOSTIC	652,857		
42	RADIOLOGY-THERAPEUTIC	139,895		
44	LABORATORY	633,762		
49	RESPIRATORY THERAPY	295,998		
50	PHYSICAL THERAPY	195,137		
52	SPEECH PATHOLOGY	2,498		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,712		
56	DRUGS CHARGED TO PATIENTS	185,967		
59	OP PSYCH	841,154		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	468,593		
62	OBSERVATION BEDS (NON-DISTINCT PART)	142,879		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	4,162,525		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104	NET CHARGES	4,162,525		

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.190453
2	PROGRAM VACCINE CHARGES	
3	PROGRAM COSTS	

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART II
14-5499		

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
52	SPEECH PATHOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	OP PSYCH						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART II
14-5499		

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO 7	COSTS 8
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM		
40	ANESTHESIOLOGY		
41	RADIOLOGY-DIAGNOSTIC		
42	RADIOLOGY-THERAPEUTIC		
44	LABORATORY		
49	RESPIRATORY THERAPY		
50	PHYSICAL THERAPY		
52	SPEECH PATHOLOGY		
55	MEDICAL SUPPLIES CHARGED		
56	DRUGS CHARGED TO PATIENTS		
59	OP PSYCH		
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
65	AMBULANCE SERVICES		
101	TOTAL		

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

I PROVIDER NO: 14-1346 I COMPONENT NO: 14-5499
I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009
I PREPARED 5/20/2010 I WORKSHEET D I PART IV

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A IE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	1.01	MED ED NRS SCHOOL COST 2	MED ED ALLIED HEALTH COST 2.01	MED ED ALL OTHER COSTS 2.02	BLOOD CLOT FOR HEMOPHILIACS 2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
52	SPEECH PATHOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	OP PSYCH						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO:	PERIOD:	PREPARED
14-1346	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART IV
14-5499		

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A E NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			924,304				
40	ANESTHESIOLOGY			492,869				
41	RADIOLOGY-DIAGNOSTIC			9,088,335			26,805	
42	RADIOLOGY-THERAPEUTIC			902,641			3,454	
44	LABORATORY			10,293,913			138,562	
49	RESPIRATORY THERAPY			2,802,165			106,054	
50	PHYSICAL THERAPY			1,368,254			137,486	
52	SPEECH PATHOLOGY			62,894			4,761	
55	MEDICAL SUPPLIES CHARGED			3,185,618			82,371	
56	DRUGS CHARGED TO PATIENTS			7,943,848			664,674	
59	OP PSYCH			1,609,955				
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY			3,715,819				
62	OBSERVATION BEDS (NON-DIS			358,815				
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES							
101	TOTAL			42,749,430			1,164,167	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO:	PERIOD:	PREPARED	5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D	
COMPONENT NO:	TO 12/31/2009	PART IV	
14-5499			

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A E NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
52	SPEECH PATHOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	OP PSYCH						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010
I COMPONENT NO: 14-1346 I WORKSHEET D PART V

TITLE XIX - O/P HOSPITAL

	Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other (1)
		1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.958929				167,541
40	ANESTHESIOLOGY	.044444				110,404
41	RADIOLOGY-DIAGNOSTIC	.215008				2,065,015
42	RADIOLOGY-THERAPEUTIC	.294624				69,673
44	LABORATORY	.166589				1,476,902
49	RESPIRATORY THERAPY	.301218				127,784
50	PHYSICAL THERAPY	.642096				118,871
52	SPEECH PATHOLOGY	.790107				3,939
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.280429				301,703
56	DRUGS CHARGED TO PATIENTS	.190453				414,611
59	OP PSYCH	.533772				22,026
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.470236				1,336,411
62	OBSERVATION BEDS (NON-DISTINCT PART)	.756195				56,182
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.200818				
101	SUBTOTAL					6,271,062
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					6,271,062

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010
I COMPONENT NO: 14-1346 I WORKSHEET D PART V

TITLE XIX - O/P HOSPITAL

	Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
		5.01	5.02	5.03	6	7
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC					
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
52	SPEECH PATHOLOGY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
59	OP PSYCH					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART V
14-1346		

TITLE XIX - O/P HOSPITAL

	Cost Center Description	Other Outpatient Diagnostic 8	All Other 9	PPS Services FYB to 12/31 9.01	Non-PPS Services 9.02	PPS Services 1/1 to FYE 9.03
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		160,660			
40	ANESTHESIOLOGY		4,907			
41	RADIOLOGY-DIAGNOSTIC		443,995			
42	RADIOLOGY-THERAPEUTIC		20,527			
44	LABORATORY		246,036			
49	RESPIRATORY THERAPY		38,491			
50	PHYSICAL THERAPY		76,327			
52	SPEECH PATHOLOGY		3,112			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		84,606			
56	DRUGS CHARGED TO PATIENTS		78,964			
59	OP PSYCH		11,757			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		628,429			
62	OBSERVATION BEDS (NON-DISTINCT PART)		42,485			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		1,840,296			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		1,840,296			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2009	PART I
14-1346		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,461
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,273
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,273
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	2,100
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	88
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,081
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	2,100
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	90.92
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	90.92
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,630,066
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	8,001
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,032,822
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,597,244
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,354,558
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,354,558
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.678363
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	719.39
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,597,244

TITLE XVIII PART A HOSPITAL OTHER

RT II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	488.01
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,015,549
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,015,549

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	562,892	410	1,372.91	304	417,365
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1,429,789
49	TOTAL PROGRAM INPATIENT COSTS	2,862,703

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	1,024,821
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	1,024,821
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2009	PART III
14-1346		

	TITLE XVIII PART A	HOSPITAL	OTHER
PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY			
			1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST		
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		
68	PROGRAM ROUTINE SERVICE COST		
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS		
72	PER DIEM CAPITAL-RELATED COSTS		
73	PROGRAM CAPITAL-RELATED COSTS		
74	INPATIENT ROUTINE SERVICE COST		
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION		
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		
78	INPATIENT ROUTINE SERVICE COST LIMITATION		
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS		
80	PROGRAM INPATIENT ANCILLARY SERVICES		
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION		
82	TOTAL PROGRAM INPATIENT OPERATING COSTS		
PART IV - COMPUTATION OF OBSERVATION BED COST			
83	TOTAL OBSERVATION BED DAYS		556
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM		488.01
85	OBSERVATION BED COST		271,334

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	1,603
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,603
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,603
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,146
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	449,875
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	449,875
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	329,101
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	329,101
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.366982
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	205.30
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	449,875

TITLE XVIII PART A SNF PPS

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	449,875
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	280.65
68	PROGRAM ROUTINE SERVICE COST	321,625
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	321,625
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	27,432
72	PER DIEM CAPITAL-RELATED COSTS	17.11
73	PROGRAM CAPITAL-RELATED COSTS	19,608
74	INPATIENT ROUTINE SERVICE COST	302,017
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	302,017
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	321,625
80	PROGRAM INPATIENT ANCILLARY SERVICES	303,538
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	625,163

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,461
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,273
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,273
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,535
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	565
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	88
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	307
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	88
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,630,066
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,027,950
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,602,116
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,354,558
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,354,558
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.680432
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	719.39
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,602,116

TITLE XIX - I/P HOSPITAL OTHER

RT II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	489.50
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	150,277
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	150,277

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	562,892	410	1,372.91		
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST	288,606
49	TOTAL PROGRAM INPATIENT COSTS	438,883

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2009	PART III
14-1346		

TITLE XIX - I/P HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	556
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	489.49
85	OBSERVATION BED COST	272,156

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2009	PART I
14-5499		

TITLE XIX - I/P SNF OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	1,603
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,603
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,603
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	329,101
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	329,101
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	205.30
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

		TITLE XIX - I/P	SNF	OTHER
PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY				
				1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST			
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM			
68	PROGRAM ROUTINE SERVICE COST			
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM			
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS			
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS			27,432
72	PER DIEM CAPITAL-RELATED COSTS			17.11
73	PROGRAM CAPITAL-RELATED COSTS			
74	INPATIENT ROUTINE SERVICE COST			
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS			
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION			
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION			
78	INPATIENT ROUTINE SERVICE COST LIMITATION			
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS			
80	PROGRAM INPATIENT ANCILLARY SERVICES			
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION			
82	TOTAL PROGRAM INPATIENT OPERATING COSTS			
PART IV - COMPUTATION OF OBSERVATION BED COST				
83	TOTAL OBSERVATION BED DAYS			
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM			
85	OBSERVATION BED COST			

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2009	PART I
-		

TITLE XIX - I/P NF OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	22,775
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	22,775
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	22,775
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,121,165
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,121,165
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	137.04
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

		TITLE XIX - I/P	NF	OTHER
				1
PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY				
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST			
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM			
68	PROGRAM ROUTINE SERVICE COST			
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM			
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS			
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS			165,361
72	PER DIEM CAPITAL-RELATED COSTS			7.26
73	PROGRAM CAPITAL-RELATED COSTS			
74	INPATIENT ROUTINE SERVICE COST			
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS			
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION			
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION			
78	INPATIENT ROUTINE SERVICE COST LIMITATION			
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS			
80	PROGRAM INPATIENT ANCILLARY SERVICES			
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION			
82	TOTAL PROGRAM INPATIENT OPERATING COSTS			
PART IV - COMPUTATION OF OBSERVATION BED COST				
83	TOTAL OBSERVATION BED DAYS			
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM			
85	OBSERVATION BED COST			

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET D-4

I COMPONENT NO: 14-1346 I

TITLE XVIII, PART A HOSPITAL OTHER

WKST A E NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,202,600	
26	INTENSIVE CARE UNIT		264,822	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.958929	61,440	58,917
40	ANESTHESIOLOGY	.044444	13,513	601
41	RADIOLOGY-DIAGNOSTIC	.215008	459,173	98,726
42	RADIOLOGY-THERAPEUTIC	.294624	62,159	18,314
44	LABORATORY	.166589	1,275,723	212,521
49	RESPIRATORY THERAPY	.301218	777,924	234,325
50	PHYSICAL THERAPY	.642096	74,504	47,839
52	SPEECH PATHOLOGY	.790107	4,001	3,161
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.280429	1,107,415	310,551
56	DRUGS CHARGED TO PATIENTS	.190453	2,328,253	443,423
59	OP PSYCH	.533772		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.470236	3,000	1,411
62	OBSERVATION BEDS (NON-DISTINCT PART)	.756195		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		6,167,105	1,429,789
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		6,167,105	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET D-4

I COMPONENT NO: 14-Z346 I

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A 'E NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.958929	3,065	2,939
40	ANESTHESIOLOGY	.044444		
41	RADIOLOGY-DIAGNOSTIC	.215008	108,203	23,265
42	RADIOLOGY-THERAPEUTIC	.294624		
44	LABORATORY	.166589	376,557	62,730
49	RESPIRATORY THERAPY	.301218	377,342	113,662
50	PHYSICAL THERAPY	.642096	209,457	134,492
52	SPEECH PATHOLOGY	.790107	3,941	3,114
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.280429	301,527	84,557
56	DRUGS CHARGED TO PATIENTS	.190453	1,474,601	280,842
59	OP PSYCH	.533772		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.470236		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.756195		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		2,854,693	705,601
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		2,854,693	

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET D-4

COMPONENT NO: 14-5499

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A 'E NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.958929		
40	ANESTHESIOLOGY	.044444		
41	RADIOLOGY-DIAGNOSTIC	.215008	26,805	5,763
42	RADIOLOGY-THERAPEUTIC	.294624	3,454	1,018
44	LABORATORY	.166589	138,562	23,083
49	RESPIRATORY THERAPY	.301218	106,054	31,945
50	PHYSICAL THERAPY	.642096	137,486	88,279
52	SPEECH PATHOLOGY	.790107	4,761	3,762
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.280429	82,371	23,099
56	DRUGS CHARGED TO PATIENTS	.190453	664,674	126,589
59	OP PSYCH	.533772		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.470236		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.756195		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		1,164,167	303,538
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,164,167	

Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2010
I 14-1346 I FROM 1/ 1/2009 I WORKSHEET D-4
I COMPONENT NO: I TO 12/31/2009 I
I 14-1346 I I

TITLE XIX HOSPITAL OTHER

WKST A E	NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
	25	ADULTS & PEDIATRICS		183,596	
	26	INTENSIVE CARE UNIT		23,632	
		ANCILLARY SRVC COST CNTRS			
	37	OPERATING ROOM	.958929	15,969	15,313
	40	ANESTHESIOLOGY	.044444	10,085	448
	41	RADIOLOGY-DIAGNOSTIC	.215008	145,185	31,216
	42	RADIOLOGY-THERAPEUTIC	.294624	8,014	2,361
	44	LABORATORY	.166589	237,808	39,616
	49	RESPIRATORY THERAPY	.301218	130,813	39,403
	50	PHYSICAL THERAPY	.642096	25,510	16,380
	52	SPEECH PATHOLOGY	.790107	112	88
	55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.280429	82,041	23,007
	56	DRUGS CHARGED TO PATIENTS	.190453	433,799	82,618
	59	OP PSYCH	.533772		
		OUTPAT SERVICE COST CNTRS			
	61	EMERGENCY	.470236	52,556	24,714
	62	OBSERVATION BEDS (NON-DISTINCT PART)	.756195	17,776	13,442
		OTHER REIMBURS COST CNTRS			
	65	AMBULANCE SERVICES			
	101	TOTAL		1,159,668	288,606
	102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
	103	NET CHARGES		1,159,668	

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,162,525
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,162,525
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,204,150
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	33,549
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	1,955,075
19	SUBTOTAL (SEE INSTRUCTIONS)	2,215,526
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,215,526
24	PRIMARY PAYER PAYMENTS	508
25	SUBTOTAL	2,215,018
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	449,266
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	449,266
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	414,000
28	SUBTOTAL	2,664,284
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,664,284
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,817,031
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-152,747
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 12/31/2009	PART B
14-5499		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		SNF
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 12/31/2009	
14-1346		

TITLE XVIII HOSPITAL

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			2,224,550		2,817,031
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			215,700		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			2,440,250		2,817,031
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01		61,110		
		SETTLEMENT TO PROGRAM .02				152,747
7	TOTAL MEDICARE PROGRAM LIABILITY			2,501,360		2,664,284

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 12/31/2009	
14-5499		

TITLE XVIII SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			335,182		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			335,182		
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 / SETTLEMENT TO PROGRAM .02		19,444		
7	TOTAL MEDICARE PROGRAM LIABILITY			354,626		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED
14-1346	FROM 1/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 12/31/2009	
14-Z346		

TITLE XVIII SWING BED SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,766,983		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			1,766,983		
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01				
		SETTLEMENT TO PROGRAM .02		80,801		
7	TOTAL MEDICARE PROGRAM LIABILITY			1,686,182		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED
14-1346	FROM 1/ 1/2009	
COMPONENT NO:	TO 12/31/2009	WORKSHEET E-2
14-Z346		

TITLE XVIII SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	1,035,069	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	712,657	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	2,100	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,747,726	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,747,726	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,747,726	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	61,544	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,686,182	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,686,182	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,766,983	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-80,801	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 12/31/2009	PART II
14-1346		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	2,862,703
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,862,703
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,891,330
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,891,330
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	499,521
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,391,809
23	COINSURANCE	
24	SUBTOTAL	2,391,809
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	109,551
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	109,551
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	96,433
26	SUBTOTAL	2,501,360
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	2,501,360
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,440,250
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	61,110
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 12/31/2009	PART III
14-5499		

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XVIII SNF

		PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE		
1	INPATIENT HOSPITAL/SNF/NF SERVICES		
2	MEDICAL AND OTHER SERVICES		
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)		
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		
6	SUBTOTAL		
7	INPATIENT PRIMARY PAYER PAYMENTS		
8	OUTPATIENT PRIMARY PAYER PAYMENTS		
9	SUBTOTAL		
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
10	ROUTINE SERVICE CHARGES		
11	ANCILLARY SERVICE CHARGES		
12	INTERNS AND RESIDENTS SERVICE CHARGES		
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
14	TEACHING PHYSICIANS		
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		
16	TOTAL REASONABLE CHARGES		
	CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		
19	RATIO OF LINE 17 TO LINE 18		
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
23	COST OF COVERED SERVICES		
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS		398,638
25	OUTLIER PAYMENTS		
26	PROGRAM CAPITAL PAYMENTS		
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
30	SUBTOTAL		398,638
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30		398,638
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		
35	SUBTOTAL		398,638
36	COINSURANCE		62,745
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19		
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		18,733
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)		
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		18,733
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)		18,733
39	UTILIZATION REVIEW		
40	SUBTOTAL (SEE INSTRUCTIONS)		354,626
41	INPATIENT ROUTINE SERVICE COST		
42	MEDICARE INPATIENT ROUTINE CHARGES		
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES		
45	RATIO OF LINE 43 TO 44		
46	TOTAL CUSTOMARY CHARGES		
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
50	OTHER ADJUSTMENTS (SPECIFY)		
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
52	SUBTOTAL		354,626
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		354,626
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
57	INTERIM PAYMENTS		335,182
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
58	BALANCE DUE PROVIDER/PROGRAM		19,444
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1346	FROM 1/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 12/31/2009	PART III
14-5499		

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XVIII SNF

IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

	PPS TITLE V OR TITLE XIX	TITLE XVIII SNF PPS
	1	2

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	437,480			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	9,047,114			
5	OTHER RECEIVABLES	64			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-5,209,114			
7	INVENTORY	145,818			
8	PREPAID EXPENSES	115,935			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS	16,667			
11	TOTAL CURRENT ASSETS	4,553,964			
	FIXED ASSETS				
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	19,313			
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	3,630,263			
16.01	LESS ACCUMULATED DEPRECIATION	-2,226,395			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	1,423,181			
	OTHER ASSETS				
22	INVESTMENTS	6,875			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	1,223			
26	TOTAL OTHER ASSETS	8,098			
27	TOTAL ASSETS	5,985,243			

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	765,435			
29	SALARIES, WAGES & FEES PAYABLE	575,901			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	258,915			
32	DEFERRED INCOME	1,700,100			
33	ACCELERATED PAYMENTS	182,664			
34	DUE TO OTHER FUNDS	255,935			
35	OTHER CURRENT LIABILITIES	837			
36	TOTAL CURRENT LIABILITIES	3,739,787			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE	414,542			
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	414,542			
43	TOTAL LIABILITIES	4,154,329			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	1,830,914			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	1,830,914			
52	TOTAL LIABILITIES AND FUND BALANCES	5,985,243			

STATEMENT OF CHANGES IN FUND BALANCES

I PROVIDER NO: 14-1346 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET G-1 I

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		983,110		
2	NET INCOME (LOSS)		-72,810		
3	TOTAL		910,300		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	0	920,614			
5	0				
6	0				
7					
8					
9					
10	TOTAL ADDITIONS		920,614		
11	SUBTOTAL		1,830,914		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	0				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		1,830,914		

		ENDOWMENT FUND 5	6	PLANT FUND 7	8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	0				
5	0				
6	0				
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	0				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	2,354,558		2,354,558
4	00	SWING BED - SNF			
5	00	SWING BED - NF			
6	00	SKILLED NURSING FACILITY	329,101		329,101
7	00	NURSING FACILITY	3,121,165		3,121,165
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	5,804,824		5,804,824
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10	00	INTENSIVE CARE UNIT	339,214		339,214
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP	339,214		339,214
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	6,144,038		6,144,038
17	00	ANCILLARY SERVICES	13,468,418	29,567,797	43,036,215
18	00	OUTPATIENT SERVICES			
20	00	AMBULANCE SERVICES		1,455,595	1,455,595
24	00	PHYSICIAN CHARGES	293,035	3,555,046	3,848,081
25	00	TOTAL PATIENT REVENUES	19,905,491	34,578,438	54,483,929

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		22,383,953	
		ADD (SPECIFY)			
27	00	ADD (SPECIFY)			
28	00				
29	00				
30	00				
31	00				
32	00				
33	00	TOTAL ADDITIONS			
		DEDUCT (SPECIFY)			
34	00	DEDUCT (SPECIFY)	51,465		
35	00		1,216,744		
36	00				
37	00				
38	00				
39	00	TOTAL DEDUCTIONS		1,268,209	
40	00	TOTAL OPERATING EXPENSES		21,115,744	

STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO: 14-1346 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	54,483,929
2	LESS: ALLOWANCES AND DISCOUNTS ON	32,262,778
3	NET PATIENT REVENUES	22,221,151
4	LESS: TOTAL OPERATING EXPENSES	21,115,744
5	NET INCOME FROM SERVICE TO PATIENT	1,105,407
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS,FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	
24.05		622,435
24.10		
25	TOTAL OTHER INCOME	622,435
26	TOTAL	1,727,842
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	240,445
28		1,560,207
29		
30	TOTAL OTHER EXPENSES	1,800,652
31	NET INCOME (OR LOSS) FOR THE PERIO	-72,810